

<i>SERFF Tracking Number:</i>	<i>ZURC-127624851</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>49785</i>
<i>Company Tracking Number:</i>	<i>CW AH 33353</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Additional Riders For Blanket Accident Insurance For All Other Groups</i>		
<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		

## Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups SERFF Tr Num: ZURC-127624851 State: Arkansas

TOI: H04 Health - Blanket Accident/Sickness

SERFF Status: Closed-Approved

State Tr Num: 49785

Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Co Tr Num: CW AH 33353

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Author: Paula Bartell

Disposition Date: 10/28/2011

Date Submitted: 09/14/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 11/28/2011

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number: CW AH 33353

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This has been filed for Out of State in Approval in New York and is pending

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Blanket, Other

Explanation for Other Group Market Type:

Groups statutorily eligible for Blanket Coverage, excluding Employers and Schools/Educational Institutions. Eligible groups shall include, but is not limited to: day care centers, camps, clubs, community and recreation centers, conferences, concerts, special events, entertainers, volunteer organizations and religious and youth sports organizations

Overall Rate Impact:

Filing Status Changed: 10/28/2011

Deemer Date:

State Status Changed: 10/28/2011

Submitted By: Paula Bartell

Created By: Paula Bartell

Corresponding Filing Tracking Number:

SERFF Tracking Number: ZURC-127624851 State: Arkansas  
Filing Company: Zurich American Insurance Company State Tracking Number: 49785  
Company Tracking Number: CW AH 33353  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups  
Project Name/Number: /CW AH 33353

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

THIS IS AN ACCIDENT ONLY PRODUCT AND DOES NOT PROVIDE COVERAGE FOR "SICKNESS".

Attached for your review are new riders for which we are seeking your approval to use with the Blanket Accident Insurance product previously filed with and authorized by your Department. As previously indicated, the Blanket Accident Insurance product and these new riders will be marketed to all statutorily eligible day care centers, camps, clubs, community and recreation centers, conferences, concerts, special events, entertainers, volunteer organizations and religious and youth sports organizations in your state consisting of two (2) or more individuals.

The Blanket Accident Insurance product and these riders may be marketed through brokers, consultants, third party administrators and sales employees.

These riders are new and are not intended to replace any other forms currently in use. The Enrollment Form replaces a previously filed and approved form.

The Blanket Accident Insurance product provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Coverage is offered on a contributory and non-contributory basis.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort has been made to submit these forms without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

This filing includes a certificate of readability and statement of variables

## Company and Contact

### Filing Contact Information

Paula Bartell, Project Manager  
1400 American Lane  
Schaumburg, IL 60196-1056

paula.bartell@zurichna.com  
847-605-6177 [Phone]  
847-605-7768 [FAX]

SERFF Tracking Number: ZURC-127624851 State: Arkansas  
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Project Name/Number: /CW AH 33353

### Filing Company Information

Zurich American Insurance Company	CoCode: 16535	State of Domicile: New York
1400 American Lane	Group Code: 212	Company Type:
Schaumburg, IL 60102	Group Name:	State ID Number:
(847) 605-6000 ext. [Phone]	FEIN Number: 36-4233459	

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### Filing Fees

Fee Required?	Yes
Fee Amount:	\$900.00
Retaliatory?	No
Fee Explanation:	18 forms X \$50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$900.00	09/14/2011	51578162

SERFF Tracking Number:	ZURC-127624851	State:	Arkansas
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TOI:	H04 Health - Blanket Accident/Sickness	Sub-TOI:	H04.000 Health - Blanket Accident/Sickness
Product Name:	Additional Riders For Blanket Accident Insurance For All Other Groups		
Project Name/Number:	/CW AH 33353		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/28/2011	10/28/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	09/29/2011	09/29/2011	Paula Bartell	10/28/2011	10/28/2011

<i>SERFF Tracking Number:</i>	<i>ZURC-127624851</i>	<i>State:</i>	<i>Arkansas</i>
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<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Additional Riders For Blanket Accident Insurance For All Other Groups</i>		
<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		

## Disposition

Disposition Date: 10/28/2011

Implementation Date: 11/28/2011

Status: Approved

HHS Status: Not Reported

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ZURC-127624851 State: Arkansas

Filing Company: Zurich American Insurance Company State Tracking Number: 49785

Company Tracking Number: CW AH 33353

TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups

Project Name/Number: /CW AH 33353

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	No
Supporting Document	Application	Approved	No
Supporting Document	PPACA Uniform Compliance Summary	Approved	No
Supporting Document	Statement of Variables	Approved	No
Supporting Document	Marked up Copy	Approved	No
Form (revised)	Enrollment Form Blanket Accident Insurance	Approved	No
Form	Enrollment Form Blanket Accident Insurance	Replaced	No
Form	[Higher] Education Benefit	Approved	No
Form	Common Carrier Benefit	Approved	No
Form	Carjacking Benefit	Approved	No
Form	Felonious Assault Benefit	Approved	No
Form	Rehabilitation Benefit	Approved	No
Form	Seat Belt [/ Air Bag] Benefit	Approved	No
Form	Critical Illness Benefit	Approved	No
Form	Coma Benefit	Approved	No
Form	Emergency Treatment Benefit	Approved	No
Form	Funeral Expense Benefit	Approved	No
Form	In-Hospital Indemnity Benefit	Approved	No
Form	Personal Property Benefit	Approved	No
Form	Terrorism Benefit	Approved	No
Form	Travel Assistance Program	Approved	No
Form	Waiver of Premium for Loss of Employment	Approved	No
Form	No Claim Discount	Approved	No
Form	Wellness Benefit	Approved	No

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 09/29/2011  
Submitted Date 09/29/2011  
Respond By Date 10/31/2011

Dear Paula Bartell,

This will acknowledge receipt of the captioned filing.

Please provide the policy form number and approval date of the policies these riders will be attached to.

### Objection 1

- Enrollment Form Blanket Accident Insurance , U-BMC-303-B AR (08/11) (Form)

Comment: All statements in a life or accident and health insurance application are considered representations and not warranties. Please add this language required by 23-79-107.

### Objection 2

- Travel Assistance Program, U-BMC-337-A CW (08/11) (Form)

Comment: Please explain all steps Zurich will take to arrange travel assistance, that when completed, will qualify the insured for this rider benefit.

The Arkansas Insurance Department will not approve exclusions for terrorism or terrorism-type activity. The Travel Assistance Benefits cannot exclude terrorism or nuclear accident.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: ZURC-127624851 State: Arkansas  
 Filing Company: Zurich American Insurance Company State Tracking Number: 49785  
 Company Tracking Number: CW AH 33353  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups  
 Project Name/Number: /CW AH 33353

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 10/28/2011  
 Submitted Date 10/28/2011

Dear Donna Lambert,

### Comments:

The following information is in response to your comments.

### Response 1

Comments: In consideration of the Department's comments, we have revised the wording on the Enrollment form. Please see revised document below. In accordance with 23-79-107, please refer to the "Time Limit on Certain Defenses provision under Section X on page 10 of the Policy form U-BMC-300-A AR which was authorized for use effective 01/04/2011 .

### Related Objection 1

Applies To:

- Enrollment Form Blanket Accident Insurance , U-BMC-303-B AR (08/11) (Form)

Comment:

All statements in a life or accident and health insurance application are considered representations and not warranties. Please add this language required by 23-79-107.

### Changed Items:

### Supporting Document Schedule Item Changes

Satisfied -Name: Marked up Copy

Comment:

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Enrollment Form Blanket Accident Insurance	U-BMC-303-B AR (08/11)		Application/Enrollment Form	Revised	47575	48.000	U-BMC-303-B AR - Enrollment

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 Filing Company: Zurich American Insurance Company State Tracking Number: 49785  
 Company Tracking Number: CW AH 33353  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups  
 Project Name/Number: /CW AH 33353

Form  
 CLN 10 27  
 2011.pdf

### Previous Version

Enrollment Form	U-BMC-	Application/Enrollment	Revised	47575	48.000	U-BMC-
Blanket Accident	303-B AR	Form				303-B AR
Insurance	(08/11)					-
						Enrollment
						Form.pdf

No Rate/Rule Schedule items changed.

## Response 2

Comments: If the Insured is covered under a policy that provides this Travel Assistance service, the Insured already qualifies for the service provided he/she is the appropriate number of miles from his/her principal residence. There is not another step to requalify the Insured once the service is on a policy that covers that Insured. Regarding the steps for arranging the travel assistance, please know that all cases are different and depend on the services selected by the Policyholder for the Insureds. The following would take place in all instances where the service is provided under the policy:

The Insured sustains an injury or illness requiring assistance under one or more services provided. This assistance does not pay for the medical services provided but will assist an Insured in coordinating his/her medical insurance with the Insured's medical insurance provider.

The Insured, or someone on his/her behalf calls in to the travel assistance service via a (800) number provided to the Insured.

Upon receipt of the telephone call, coverage is verified by the dedicated account executive that the person is covered under the policy and what travel assistance services are available.

The account executive works with the doctors, hospitals, nurses to determine the stability of the Insured for transportation.

The account executive will provide the any/all of the services offered under the policy at that time.

With regard to the Department's comments on the Travel Assistance Rider, form U-BMC-337-A CW, the Reservation of Rights provision contained within the Travel Assistance Program Rider does not exclude terrorism or nuclear accidents. The Reservation of Rights provision is merely stating that we reserve the right to not provide Travel Assistance services in areas that are experiencing a terrorism or nuclear accident, because the entities/individuals providing the Travel Assistance services either can't get to the area and/or we want to avoid placing those entities/individuals in danger.

SERFF Tracking Number: ZURC-127624851 State: Arkansas  
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Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups  
Project Name/Number: /CW AH 33353

#### **Related Objection 1**

Applies To:

- Travel Assistance Program, U-BMC-337-A CW (08/11) (Form)

Comment:

Please explain all steps Zurich will take to arrange travel assistance, that when completed, will qualify the insured for this rider benefit.

The Arkansas Insurance Department will not approve exclusions for terrorism or terrorism-type activity. The Travel Assistance Benefits cannot exclude terrorism or nuclear accident.

#### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Paula Bartell

SERFF Tracking Number: ZURC-127624851 State: Arkansas

Filing Company: Zurich American Insurance Company State Tracking Number: 49785

Company Tracking Number: CW AH 33353

TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups

Project Name/Number: /CW AH 33353

## Form Schedule

### Lead Form Number: U-BMC-300

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/28/2011	U-BMC-303-B AR (08/11)	Application/ Enrollment Form Enrollment Blanket Accident Insurance	Revised	Replaced Form #: U- 48.000 BMC-303-A AR (07/10) Previous Filing #: 47575		U-BMC-303-B AR - Enrollment Form CLN 10 27 2011.pdf
Approved 10/28/2011	U-BMC-310-A CW (08/ 11)	Policy/Cont [Higher] Education ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		47.000	U-BMC-310-A CW - [Higher] Education Benefit.pdf
Approved 10/28/2011	U-BMC-311-A CW (08/ 11)	Policy/Cont Common Carrier ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		43.000	U-BMC-311-A CW - Common Carrier Benefit.pdf
Approved 10/28/2011	U-BMC-313-A CW (08/ 11)	Policy/Cont Carjacking Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme	Initial		40.000	U-BMC-313-A CW - Carjacking Benefit.pdf

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<i>Company Tracking Number:</i>	<i>CW AH 33353</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Additional Riders For Blanket Accident Insurance For All Other Groups</i>		
<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		

  

Approved	U-BMC-	nt or Rider			
10/28/2011	314-A CW	Policy/Cont Felonious Assault	Initial	43.000	U-BMC-314-A
	(08/ 11)	ract/Fratern Benefit			CW -
		al			Felonious
		Certificate:			Assault
		Amendmen			Benefit.pdf
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Rehabilitation Benefit	Initial	43.000	U-BMC-315-A
10/28/2011	315-A CW	ract/Fratern			CW -
	(08/11)	al			Rehabilitation
		Certificate:			Benefit.pdf
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Seat Belt [/ Air Bag]	Initial	37.000	U-BMC-316-A
10/28/2011	316-A CW	ract/Fratern Benefit			CW - Seat
	(08/11)	al			Belt [Air Bag]
		Certificate:			Benefit.pdf
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Critical Illness Benefit	Initial	40.000	U-BMC-321-A
10/28/2011	321-A AR	ract/Fratern			AR - Critical
	(08/11)	al			Illness
		Certificate:			Benefit.pdf
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Coma Benefit	Initial	52.000	U-BMC-327-A

<i>SERFF Tracking Number:</i>	<i>ZURC-127624851</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>CW AH 33353</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
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<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		

  

10/28/2011	327-A AR	ract/Fratern			AR - Coma
(08/11)		al			Benefit.pdf
		Certificate:			
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Emergency	Initial	42.000	U-BMC-329-A
10/28/2011	329-A CW	ract/Fratern Treatment Benefit			CW -
(08/11)		al			Emergency
		Certificate:			Treatment
		Amendmen			Benefit.pdf
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Funeral Expense	Initial	50.000	U-BMC-330-A
10/28/2011	330-A CW	ract/Fratern Benefit			CW - Funeral
(08/11)		al			Expense
		Certificate:			Benefit.pdf
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont In-Hospital Indemnity	Initial	45.000	U-BMC-332-A
10/28/2011	332-A AR	ract/Fratern Benefit			AR - In-
(08/11)		al			Hospital
		Certificate:			Indemnity
		Amendmen			Benefit.pdf
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-BMC-	Policy/Cont Personal Property	Initial	29.000	U-BMC-334-A
10/28/2011	334-A CW	ract/Fratern Benefit			CW -
(08/11)		al			Personal

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Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups  
Project Name/Number: /CW AH 33353

		Certificate:		Property
		Amendmen		Benefit.pdf
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved	U-BMC-	Policy/Cont Terrorism Benefit	Initial	42.000
10/28/2011	336-A CW	ract/Fratern		
	(08/11)	al		
		Certificate:		U-BMC-336-A
		Amendmen		CW -
		t, Insert		Terrorism
		Page,		Benefit.pdf
		Endorseme		
		nt or Rider		
Approved	U-BMC-	Policy/Cont Travel Assistance	Initial	44.000
10/28/2011	337-A CW	ract/Fratern Program		
	(08/11)	al		
		Certificate:		U-BMC-337-A
		Amendmen		CW - Travel
		t, Insert		Assistance
		Page,		Program.pdf
		Endorseme		
		nt or Rider		
Approved	U-BMC-	Policy/Cont Waiver of Premium	Initial	45.000
10/28/2011	344-A CW	ract/Fratern for Loss of		
	(08/11)	al Employment		
		Certificate:		U-BMC-344-A
		Amendmen		CW - Waiver
		t, Insert		of
		Page,		Premium.pdf
		Endorseme		
		nt or Rider		
Approved	U-BMC-	Policy/Cont No Claim Discount	Initial	58.000
10/28/2011	345-A CW	ract/Fratern		
	(08/11)	al		
		Certificate:		U-BMC-345-A
		Amendmen		CW - No
				Claim
				Discount.pdf

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<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Additional Riders For Blanket Accident Insurance For All Other Groups</i>		
<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved U-BMC- 10/28/2011 346-A CW (08/11)	Policy/Cont Wellness Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	38.000
			U-BMC-346-A CW - Wellness Benefit.pdf

# Enrollment Form

## Blanket Accident Insurance



**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of <b>Policyholder</b> :	[Master Policy Number:]

ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):		Last 4 Digits of SSN: XXX-XX-	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married [ <input type="checkbox"/> Domestic Partner]	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -
Requested Effective Date (MM/DD/YYYY):	[Certificate Number (assigned by the Company): ]		

PARENT OR LEGAL GUARDIAN INFORMATION (if Enrollee is a Minor)			
Full Legal Name (First, Middle Initial and Last):		Relationship to Enrollee: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -

INSURANCE REQUESTED	
[Benefit(s) Included:	Coverage Amount
[Accidental Death Benefit]	[as per the Policy Schedule]
[Accidental Dismemberment Benefit]	[as per the Policy Schedule]
[Exposure and Disappearance Benefit]	[as per the Policy Schedule]
[Accident Weekly Indemnity Benefit]	[as per the Policy Schedule]
[Catastrophe Cash Benefit]	[as per the Policy Schedule]
[Accident Medical Expense Benefit]	[as per the Rider]
[Accident Excess Integrated Medical Expense Benefit]	[as per the Rider]
[Accident Excess Corridor Medical Expense Benefit]	[as per the Rider]
[Heart Failure Benefit]	[as per the Policy Schedule]
[Policyholder Sponsored Activity Benefit]	[as per the Policy Schedule]
[Parent Reimbursement Benefit]	[as per the Policy Schedule]



<input type="checkbox"/> [Common Carrier Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Critical Illness Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Emergency Treatment Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Felony Assault Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Funeral Expense Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Higher Education Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [In-Hospital Indemnity Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Personal Property Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Rehabilitation Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Seat Belt/Air Bag] Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Terrorism Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Travel Assistance Program]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]
<input type="checkbox"/> [Wellness Benefit]	[\$ ] [in increments of \$25] not to exceed \$1,000]
<input type="checkbox"/> [ ]	[ ]]

[CRITICAL ILLNESS BENEFIT QUESTIONNAIRE	
1. Has the Enrollee ever been diagnosed with or treated for any of the following ( <i>Oregon residents only</i> : during the past ten (10) years):	
a. heart attack, angina, high blood pressure, chest pains, disease or disorder of the heart or circulatory system, diabetes?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?	<input type="checkbox"/> YES <input type="checkbox"/> NO]
2. Has the Enrollee ever tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or treated for acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has the Enrollee ever been advised of the need for a transplant, been evaluated for a transplant and/or currently on a transplant waiting list?	<input type="checkbox"/> YES <input type="checkbox"/> NO]

BENEFICIARY DESIGNATION		
Primary Beneficiary:		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
<b>Contingent Beneficiary:</b>		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

<b>PREMIUM INFORMATION:</b>	
Enrollee:	[\$0.000] [per \$[1,000] of <b>Principal Sum</b> ] [per month]
[Annual Premium Option:	[\$40.00]]
Frequency of Payment: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	
Method of Payment: <input type="checkbox"/> Credit Card <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/> Agency Bill [The Enrollee, or if the Enrollee is a minor, the Enrollee's Parent or Legal Guardian, must complete a separate authorization form for a [Credit Card] [or] [Bank Draft] payment.]	

### INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Enrollee hereby enrolls for Accident Insurance and represents that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

### It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic):	Date:
Parent or Legal Guardian's Signature (may be electronic):	Date:

<b>[AGENT INFORMATION]</b>	
Name of Agent:	Agent's State License Number:
Agent's Signature:	[Producer Number:     ]]

# [Higher] Education Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If the **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Benefit, **We** will pay an additional benefit for [higher] education expenses incurred for each **Dependent Child**.

[A **Dependent Child** is eligible for the [Higher] Education Benefit if on the date of the **Covered Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Covered Accident**.]

The [Higher] Education Benefit will be equal to the amount shown on the Schedule per **Dependent Child**. [This amount will be paid annually for up to [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of [higher] learning on a full-time basis.]

[If, at the time of the **Covered Accident**, there are no **Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [\$1,000] to the designated beneficiary.]

For purposes of this rider only, **Dependent Child(ren)** means those unmarried **Dependent Child(ren)** of the **Insured**, [and] [those unmarried **Dependent Child(ren)** of his or her **Spouse[/Domestic Partner]]** who rely on the **Insured** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Common Carrier Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit, **We** will pay an additional benefit equal to the amount on the Schedule, provided the **Insured** suffers the **Covered Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this rider only, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire; and
2. any civilian aircraft that holds a certificate of Public Conveyance and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Carjacking Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit, as a direct result of a **Covered Accident** that occurs during a **Carjacking** of a private passenger vehicle that the **Insured** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to the amount shown on the Schedule.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24) hours] of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24) hours] or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this rider only, the following additional definitions apply:

**Carjacking** means a person other than the **Insured**, or a member of his or her **Family** or **Household**, taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

**Family** means the **Insured's** parent, stepparent, **Spouse[/Domestic Partner]** or former **Spouse[/Domestic Partner]**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

**Household** means a person who maintains residence at the same address as the **Insured**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Felonious Assault Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit as a result of a violent or criminal act committed by someone other than the **Insured**, [a **Fellow Employee**] or a member of his or her **Family** or **Household**, **We** will pay an additional benefit equal to the amount shown on the Schedule.

For purposes of this rider only, the following additional definitions apply:

**[Fellow Employee]** means a person employed by the same employer as the **Insured** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the felonious assault was committed.]

**Family** means the **Insured's** parent, stepparent, **Spouse[/Domestic Partner]** or former **Spouse[/Domestic Partner]**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

**Household** means a person who maintains residence at the same address as the **Insured**.

This benefit applies only to the crimes or attempted crimes considered to be a felony by the local jurisdiction.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Rehabilitation Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Dismemberment] Benefit, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2) years] from the date of the **Covered Accident** for the **Rehabilitation Training**; or
2. the maximum amount shown on the Schedule.

For purposes of this rider only, the following additional definitions apply:

**Reasonable and Customary** expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

**We** reserve the right to make the final determination of what is **Reasonable and Customary**.

**Rehabilitation Training** means a treatment program that:

1. is prescribed by a **Physician** that is approved by **Us** prior to the provision of services;
2. is required due to the **Insured's Covered Injury**;
3. prepares the **Insured** for an occupation that he or she would not have engaged in except for the **Covered Injury**; and
4. is not the result of a **Pre-existing Condition**.

**Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [6] months immediately preceding the **Covered Loss**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Seat Belt[/Air Bag] Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit, and the **Covered Injury** [which caused the **Accidental** death] directly resulted from a motor vehicle **Covered Accident**, **We** will pay an additional Seat Belt Benefit, which equals the amount shown on the Schedule, provided that the **Insured** was:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the **Insured's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the motor vehicle **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional Air Bag Benefit equal to the amount shown on the Schedule, will be paid if the **Insured** was driving a private passenger motor vehicle with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger motor vehicle with a manufacturer equipped passenger-side air bag, provided the **Insured's** seat belt or lap and shoulder restraint was properly fastened at the time of the motor vehicle **Covered Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the motor vehicle **Covered Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a Seat Belt [or Air Bag] Benefit to the **Insured** that was driving either:

1. under the influence of alcohol:
  - a. An **Insured** will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the motor vehicle **Covered Accident** occurred;
  - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Critical Illness Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

CAUTION: This is a limited policy. Read it carefully with the outline of coverage

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

1. **Benefit** - Under the terms of this Critical Illness Benefit, **We** will pay the **Insured** the **Coverage Amount** as a benefit payment if:
  - a. the **Insured** is diagnosed by a **Physician** as having a **Covered Condition** and the diagnosis is made while this Critical Illness Benefit is in force;
  - b. the **Covered Condition** first occurs after the **Waiting Period**; and
  - c. none of the exclusions or limitations described in this Critical Illness Benefit apply.

If the **Insured** dies before **We** receive notice of a claim under the **Policy**, no Critical Illness Benefit is payable.

2. **Coverage Amount** - The **Coverage Amount** is that amount shown on the Schedule and will be reduced as described below:
  - a. The **Coverage Amount** will be reduced to [50] percent of the **Coverage Amount** when the **Insured** reaches age [65].
  - b. [If the sum of the **Coverage Amounts** on this and any other Critical Illness Benefit or Critical Illness Policy issued by **Us** on the life of the **Insured** exceeds [\$250,000], the **Coverage Amount** for each such Benefit and Policy will be decreased proportionately such that the sum of the **Coverage Amounts** becomes [\$250,000] before any claim is paid. **We** will adjust the premiums for such Benefits and Policies and refund to the **Insured** the excess of premiums already paid over the premiums that should have been paid for the new **Coverage Amount**, without interest.]
3. **Covered Conditions** - The following are **Covered Conditions**. If a condition is not listed in this subsection, it is not a **Covered Condition** and coverage under this Critical Illness Benefit does not apply.

[**Cancer/Cancerous** is a malignant neoplasm (including lymphatic and hematological malignancy) characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. To qualify for the **Coverage Amount**, the **Diagnosis of Cancer** must be supported by histological evidence of malignancy, must be made by a Pathologist **Physician**, and the **Cancer** must first occur after a [thirty(30)]day **Waiting Period**. Clinical Diagnosis of Cancer shall be accepted as evidence that cancer exists when a pathological diagnosis is medically inappropriate.

Excluded from coverage are:

- a. Benign tumors or polyps that are histologically described as non-malignant, pre-malignant or non-invasive.
- b. All tumors, benign or malignant, in the presence of HIV infection.
- c. All skin Cancers with the exception of invasive melanoma classified as Clark level II or higher or having a thickness measured in excess of 0.75mm.
- d. Carcinoma in situ (defined as being in position and not extending beyond the focus or level of origin).

- e. All tumors of the prostate, unless having progressed to at least TNM classification T2N0M0 or histologically classified as having a Gleason score greater than 6.
- f. Chronic Lymphocytic Leukemia (CLL) unless Rai Stage 3 or greater.
- g. Papillary microinvasive Cancer of the thyroid, bladder, cervix, or breast.]

**[Heart Attack (Myocardial Infarction)]** is the death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply. To qualify for the **Coverage Amount**, the **Diagnosis** of a **Heart Attack** must be made by a **Physician** and the **Heart Attack** must first occur after a [30-day] **Waiting Period**. The **Diagnosis** must be supported by all of the following:

- a. A history consistent with **Heart Attack**;
- b. New electrocardiogram (EKG) changes demonstrating significant Q waves (duration greater than or equal to .04 seconds and a depth greater than or equal to 5 mm) or loss of R waves diagnostic of a **Heart Attack**;
- c. Elevation of cardiac enzymes, including CPK-MB and troponin; and
- d. If performed, nuclear imaging scan or echocardiogram consistent with **Myocardial Infarction**.

[Excluded from coverage are all other heart disorders, including but not limited to: congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, and all other dysfunctions of the cardiovascular system, unless also accompanied by a **Heart Attack** as defined above.]]

**[Kidney Failure]** is the chronic and irreversible failure of both kidneys to excrete metabolites or retain electrolytes. To qualify for the **Coverage Amount**, the **Diagnosis** of **Kidney Failure** must be made by a Nephrological **Physician**. The **Kidney Failure** must require either chronic dialysis or transplantation and must first occur after a [30-day] **Waiting Period**.]

**[Loss of Limb(s)]** - The loss of one or more limbs (arms or legs) as a result of a **Covered Injury**. To qualify for the **Coverage Amount**, the **Loss of Limb(s)** must involve complete and permanent severance of one or more limbs through or above the elbow or knee joint. The **Loss of Limb(s)** must be uncorrectable by surgery or any other means. To qualify for the **Coverage Amount**, the **Loss of Limb(s)** must first occur after a [30-day] **Waiting Period**.

[Excluded from coverage is **Loss of Limb(s)** due to a disease process.]]

**[Major Organ Transplant]** is the receipt by transplant of human bone marrow or an entire human heart, kidney, lung, pancreas or liver. To qualify for the **Coverage Amount**, the **Major Organ Transplant** must be performed by a **Physician** and must first occur after a [30-day] **Waiting Period**.]

**[Paralysis]** is the loss of motor function due to neurological injury. To qualify for the **Coverage Amount**, the **Diagnosis** of **Paralysis** must be made by a Neurological **Physician**. There must be complete and permanent loss of use of both legs (complete paraplegia or quadriplegia) through neurological trauma or **Accident** to the spinal cord. The **Paralysis** must have been present for a continuous period of at least [90] days. To qualify for the **Coverage Amount**, the **Paralysis** must first occur after a [30-day] **Waiting Period**.]

[Excluded from coverage is **Paralysis** resulting from any neurological disease, including but not limited to, Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS).]]

**[Stroke (Cerebrovascular Accident)]** is the sudden loss of neurological function due to an ischemic or hemorrhagic intracranial vascular event. To qualify for the **Coverage Amount**, the **Diagnosis** of **Stroke** must be made by a **Physician** and the **Stroke** must first occur after a [30-day] **Waiting Period**. The **Stroke** must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [30] days and be verified by computed tomography (CT) scan or magnetic resonance imaging (MRI).

[Excluded from coverage are:

- a. Neurological symptoms due to transient ischemic attack (TIA);
- b. Brain injury resulting from trauma or generalized anoxia (hypoxia); and
- c. Vascular disease affecting the eye, optic nerve, or vestibular function.]]

4. **Waiting Period** means the continuous period of time beginning on the later of the effective date of this Critical Illness Benefit or the effective date of reinstatement, and ending on the last day of the **Waiting Period** specified for each **Covered Condition**. The **Insured** must be covered continuously under this Critical Illness Benefit before the **Coverage Amount** may be payable and the **Covered Condition** must first occur after the **Waiting Period**. If the **Insured's Covered Condition** first occurs prior to or during the **Waiting Period**, no Critical Illness Benefit is payable, the coverage will terminate, and **We** will refund to the **Insured** all premiums paid for this Critical Illness Benefit without interest. A **Covered Condition** shall be considered to have first occurred when symptoms or laboratory and/or clinical findings that lead to the **Diagnosis** of a **Covered Condition** are first documented in the **Insured's** medical records regardless of the date upon which the **Diagnosis** is actually made.
5. **[Preexisting Condition** means a condition for which symptoms existed within [two years] prior to the later of the effective date of this Critical Illness Benefit or the effective date of reinstatement. If the **Insured** is **Diagnosed** with a **Covered Condition** that is determined by a **Physician** at **Our** expense to be a **Preexisting Condition**, no Critical Illness Benefit is payable for that **Covered Condition** until twelve (12) months after the effective date of coverage under this Rider.]
6. **Diagnosis/Diagnosed** means the definitive establishment, acceptable to **Us**, of the **Covered Condition** through the use of clinical and/or laboratory findings and subject to the terms and conditions of this Critical Illness Benefit. The **Diagnosis** must be made by a **Physician** who is a board-certified specialist where required under the terms of this Critical Illness Benefit.
7. Payment of the **Coverage Amount** is subject to all of the following conditions:
  - a. The sum of the **Coverage Amounts** payable under this Critical Illness Benefit and any other Critical Illness Benefit or Critical Illness Policy issued by **Us** on the life of the **Insured** may not exceed [\$250,000].
  - b. Only one **Coverage Amount** payment is allowed during the lifetime of the **Insured**, as defined by the terms and conditions of this Critical Illness Benefit.
  - c. **We** must receive proof of eligibility that is acceptable to **Us**.
  - d. **We** must receive a consent form from all irrevocable beneficiaries and permitted assignees, if any. **We** also reserve the right to require a consent form from the **Insured** and the **Insured**, their spouse's, other beneficiaries, and any other person, if in **Our** sole discretion, such person's consent is necessary to protect **Our** interests.
  - e. This Critical Illness Benefit is not meant to cause involuntary access to proceeds. Therefore, this Critical Illness Benefit will be restricted to a refund of the premiums paid to date for this Critical Illness Benefit without interest if the **Insured** is:
    - i. required by law to use this Critical Illness Benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
    - ii. required by a government entity to use this Critical Illness Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement or for any other reason.
8. Exclusions and Limitations

In addition to any other conditions, exclusions or limitations set forth in this Critical Illness Benefit, as well as in the **Policy/Certificate**, no coverage will be provided if the **Covered Condition** is caused by, occurs during or results from:

  - a. [Participation in the commission or attempted commission of a felony.]
  - b. [Voluntary participation in a riot or insurrection.]
  - c. [Refusing certain types of recommended medical treatment, as follows:
    - i. [A **Physician** has recommended treatment with angioplasty or coronary artery bypass graft for coronary artery disease, the **Insured** refuses this treatment, and the **Insured** suffers a **Heart Attack**];
    - ii. [A **Physician** has recommended treatment for a brain aneurysm or carotid artery stenosis, the **Insured** refuses treatment, and the **Insured** suffers a **Stroke**];[or]
    - iii. [A **Physician** has recommended a diagnostic biopsy or diagnostic/therapeutic excision of a mass or lesion suspected of being **Cancerous**, the **Insured** refuses, and the **Insured** develops **Cancer**.]]

If the **Insured** is **Diagnosed** with a **Covered Condition** that **We** determine to be a **Preexisting Condition**, no **Coverage Amount** is payable for that **Covered Condition** until twelve (12) months after the effective date of coverage under this Rider. Furthermore, **We** will not pay the **Coverage Amount** for a **Covered Condition** if:

- a. Such **Covered Condition** has not been **Diagnosed** by a **Physician**;
  - b. Such **Covered Condition** was not **Diagnosed** until the Critical Illness Benefit had terminated; or
  - c. The **Insured's** date of birth or age was misstated on the application and, using the correct date of birth or age, the Critical Illness Benefit would not have become effective or would have terminated prior to **Diagnosis** of a **Covered Condition**.
9. After the **Coverage Amount** is paid, this Critical Illness Benefit will terminate.
10. **We** will provide a statement to the **Insured**, any irrevocable beneficiary, and any permitted assignees, showing the effect of the **Coverage Amount** payment on the **Policy** when the **Insured** receives payment of the **Coverage Amount**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Coma Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** within [365] days of a **Covered Accident**, and such **Covered Injury** causes the **Insured** to be in a **Coma**, **We** will pay a Coma Benefit.

The Coma Benefit is equal to the amount shown on the Schedule and will be paid each month the **Insured** remains in a **Coma**. [The Coma Benefit will be payable per the Schedule per month for the first [eleven (11)] months the **Insured** remains in a **Coma**. At the end of the [eleven (11)] months of payment, if the **Insured** remains in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the [eleven (11)] months of benefit already received.]

The Coma Benefit will end on the earliest of the following:

1. the date the **Insured** is no longer in a **Coma** that resulted directly from the **Covered Injury**; or
2. the **Insured** has received the full Coma Benefit for [11] months.

For purposes of this rider only, **Coma** means a profound state of unconsciousness from which the **Insured** cannot be aroused to consciousness, even by powerful stimulation, as determined by a **Physician**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Emergency Treatment Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** that results in a **Covered Loss** and, within [forty-eight (48)] hours of the **Covered Accident**, is required to receive **Medically Necessary Emergency Treatment** [in the emergency room of a **Hospital**], **We** will pay the amount shown on the Schedule. Only one Emergency Treatment Benefit[, the largest,] is payable for any one **Covered Accident** per **Insured**. [The maximum number of Emergency Treatment Benefits payable per calendar year per **Insured** regardless of the number of **Covered Accidents** incurred, is shown on the Schedule.]

For purposes of this rider only, the following additional definitions apply:

**Emergency Treatment** means treatment for:

1. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the person (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**[Hospital]** means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

**Hospital** does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.]

**Medically Necessary** means an **Emergency Treatment** that:

1. is essential for the diagnosis, treatment, and care of the **Covered Injury**;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision, or order.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Funeral Expense Benefit



**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

## **THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** sustains a **Covered Injury** that results in a **Covered Loss** payable under the [Accidental Death] Benefit, **We** will pay an additional Funeral Expense Benefit equal to the amount shown on the Schedule.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# In-Hospital Indemnity Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** that requires **Hospital Confinement** for more than [seven (7)] consecutive days, **We** will pay the amount shown on the Schedule for a maximum of [twelve (12)] months for any **Covered Injury**. To be eligible for this benefit, the initial **Hospital Confinement** period must begin within [ninety (90)] days of the **Covered Injury**.

Successive periods of **Hospital Confinement** arising out of the same **Covered Injury** will be considered one confinement only if they are separated by a period of less than [three (3)] months.

For purposes of this rider only, the following additional definitions apply:

**Hospital** means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

**Hospital** does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

**Hospital Confinement** means admission to a **Hospital** as an inpatient for at least [twenty-four (24)] consecutive hours by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to the **Insured** is not a **Hospital Confinement** under this rider unless there is no charge because the **Hospital** is a United States government facility.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Personal Property Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** requiring emergency medical attention by a **Physician** resulting in a **Covered Loss** as a result of a **Covered Accident**, and due to that same **Covered Accident** the **Insured** sustains a loss or destruction to **Personal Property**, **We** will pay a benefit [after satisfaction of the Deductible per **Covered Accident**] up to the amount shown on the Schedule [provided **We** receive an incident report from a police or security authority].

[**We** will require valid receipts of replacement **Personal Property** prior to payment of any benefits.]

**Personal Property** includes but is not limited to the following items [that are originally issued by a [police][fire][security] department and for which the **Insured** is financially responsible to return or replace]: clothing, musical instruments, cameras, jewelry, watches, furs, radios, [uniform, radio, baton, cuffs, protective vest, handgun, helmet, boots, and other items that would typically accompany a [police][security officer][fireman] in his or her daily duties]. **Personal Property** does not include laptop computers or currency.

This benefit does not apply to the destruction of **Personal Property** through normal wear and tear, mechanical breakdown, vermin, or physical abuse or neglect of the **Personal Property** by the **Insured**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Terrorism Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] Benefit, that was directly caused by an **Act of Terrorism** [within the **United States**] [outside of the **United States**], **We** will pay an additional benefit equal to the amount shown on the Schedule.

For purposes of this rider only, the following additional definition[s] appl[y][ies]:

**Act of Terrorism** means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

**[United States]** means the United States of America [including] [excluding] its territories, possessions, and protectorates.]

**We** may cancel this Terrorism Benefit rider by sending the **Policyholder** at their most recent address in **Our** records, a [ten (10)] day notice of **Our** intent to cancel.

Upon cancellation of this rider, **We** will return any unearned premium that the **Policyholder** has paid, but this is not a condition of termination. A change in or termination of this rider will not affect a claim that began while this rider was in force. In the event of cancellation of this rider, the **Policyholder** is responsible for notifying all **Insureds**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Travel Assistance Program



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

This Travel Assistance Program will apply to an **Insured** when he or she is traveling [100] mile(s) or more from their **Principal Residence**.

The transportation and/or services provided under this Travel Assistance Program must be pre-authorized by **Us**. Under this rider the Travel Assistance Program consists of the following:

### MEDICAL EVACUATION

If an **Insured** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care [in accordance with **Western Medical Standards**], **We** will arrange for, and cover the cost for, the transport of the **Insured** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital, medical facility, clinic, or medical provider. [The maximum amount **We** will pay for Medical Evacuation is equal to the amount shown on the Schedule.]

### MEDICAL REPATRIATION

If an **Insured** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel on a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured** to his or her **Principal Residence**, or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation, and the special equipment and/or personnel which are covered. [The maximum amount **We** will pay for Medical Repatriation is shown on the Schedule].

### NON-MEDICAL REPATRIATION

If an **Insured** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion. [The maximum amount **We** will pay for Non-Medical Repatriation is shown on the Schedule].

### RETURN OF REMAINS

If an **Insured** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services

and transportation for benefits to be payable. [The maximum amount **We** will pay for Return of Remains is shown on the Schedule].

### VISIT TO HOSPITAL

If an **Insured** is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured** to visit the **Insured** while he or she is hospitalized. **We** must pre-authorize the transportation for benefits to be payable. [The maximum amount **We** will pay for Visit to Hospital is shown on the Schedule.].

### RETURN OF CHILD

If an **Insured** is traveling with [a] **Dependent Child(ren)**, who [is] [are] under [nineteen (19)] years of age or [a] **Dependent Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remain[s] chiefly dependent upon the **Insured** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured**, such **Dependent Child(ren)** [is] [are] left unattended, **We** will arrange for, and cover the cost of, the transport of the **Dependent Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured**, and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Dependent Child(ren)** and attendant, if applicable, for benefits to be payable. [The maximum amount **We** will pay for Return of Child is shown on the Schedule.].

### RETURN OF COMPANION

If an **Insured** is traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured** the **Insured** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable. [The maximum amount **We** will pay for Return of Companion is shown on the Schedule].

### TRAVEL ASSISTANCE PROGRAM EXCLUSIONS

**We** will not provide this Travel Assistance Program if Coverage is excluded under Section IV General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment.
2. [the **Illness** requiring medical services resulted from the **Insured** being under the influence of any controlled substance, unless such controlled substance was prescribed by a **Physician** and was taken in accordance with the prescribed dosage.]
3. [with respect to a medical evacuation, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination.]
4. with respect to medical evacuation, it is not medically necessary to transport the **Insured** to another hospital or medical facility. **We** have the sole discretion in making that determination.
5. based upon the medical condition of the **Insured** and/or the local conditions and circumstances, **We** determine that medical evacuation or medical repatriation is not appropriate. **We** have sole discretion in making that determination.
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this Program. **We** will be fully and completely excused from performance and discharged from any contractual obligation.
7. **We** did not pre-authorize the transportation and/or services[;][.]
8. [the **Illness** resulted in whole or in part from the **Insured** being intoxicated. An **Insured** will be conclusively presumed to be intoxicated if on or about the time of the incident which required medical treatment the level of alcohol in his or her blood exceeds the amount at which a person is presumed to be intoxicated if operating a motor vehicle in that jurisdiction. A report from a law enforcement officer, medical provider or similar report will be considered proof of the **Insured's** intoxication.]

For purposes of this rider only, the following additional definitions apply:

**Covered Trip** means when an **Insured** is traveling more than [100] miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the Travel Assistance Program Exclusions set forth above.

**Dependent Child(ren)** means those unmarried **Dependent Child(ren)** of the **Insured**, [and] [those unmarried **Dependent Child(ren)** of his or her **Spouse**/[**Domestic Partner**]] who rely on the **Insured** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.

**Illness** or **Ill** means a sickness or disease which impairs normal functions of the body.

**Injured, Injury, or Injuries** means a bodily injury or injuries and is not limited to accidental bodily injuries.

**Principal Residence** means the legal domicile of the **Insured**.

[**Western Medical Standards** means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.]

For purposes of this rider only, if there are any differences in the definition of a term between this rider and the **Policy/Certificate**, the definition in this rider will govern.

## **TRAVEL ASSISTANCE PROGRAM – OTHER PROVISIONS**

### **Right of Recovery**

**We** have the right to recover any benefits that **We** paid under this Travel Assistance Program if the **Policyholder** or **Insured** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured** that were covered under this Travel Assistance Program. **We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured** for transportation services and/or expenses, which were not covered under this Travel Assistance Program.

### **[Excess Coverage]**

**Our** obligation to pay the **Policyholder** or **Insured** under this Travel Assistance Program will be excess of any other insurance which the **Policyholder** or **Insured** has with respect to the expenses covered under this Travel Assistance Program.]

### **Reservation of Rights**

**We** reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services [or in any country for which a travel warning has been issued by the Department of State of the United States of America].

### **[Exempted Countries]**

This Travel Assistance Program is not available in the following countries: [Iran]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to the **Policyholder**.]

### **Scope**

[Covered transportation expenses will be limited to air and marine conveyance.]

**Illness**, as covered under this Travel Assistance Program, is solely covered under this Travel Assistance Program, and in no way supersedes or modifies the other Benefits provided under the **Policy**.

[To contact **Us** regarding this Travel Assistance Program, the **Insured** must call [1-800-263-0261] from the U.S. or Canada; and collect from anywhere else in the world at [+1-416-977-0277].]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# Waiver of Premium Due to Loss of Employment Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** becomes **Unemployed** while covered under this **Policy**, **We** will waive the premium due from him or her under this **Policy**, provided the **Unemployment** continues for a period greater than [180] consecutive days.

Premium payments must continue for the first [180] days of the continuous **Unemployment**. After the initial [180] day period of continuous **Unemployment**, the **Insured's** premium for this **Policy** will be waived until the earliest of the following:

1. the **Insured** is no longer **Unemployed**;
2. the **Policy** terminates;
3. [60] days expired since the Waiver of Premium was granted by **Us**; or
4. [the **Insured** attains age [70]].

For purposes of this rider only, **Unemployed/Unemployment** means that the **Insured** was a full-time employee for a continuous period of [180] days immediately prior to the request for Waiver of Premium and was involuntarily discharged from that employment and is registered for **Unemployment** benefits with the appropriate government employment agency.

To apply for this Waiver of Premium benefit, the **Insured** must notify **Us** in writing of the **Insured's Unemployment** and request a Waiver of Premium Form. The form must be completed by the **Insured** and sent to **Us** as provided under the REPORTING AND NOTICE ADDRESSES section of the Schedule.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

# No Claim Discount



**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

## **THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If after the **Insured's** coverage under the **Policy** has been in force for [three (3)] years, and no claim has been filed or paid under the **Policy**, [except for Wellness Benefits], the **Insured** is entitled to a **No Claim Discount**.

For purposes of this rider only, a **No Claim Discount** means a one-time premium reduction of [10%] off the annual premium as stated on the Schedule. The **No Claim Discount** will become effective on the next renewal term and will remain in effect for each subsequent [anniversary] [renewal term] until such time as a claim may be filed or paid.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

## Wellness Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

### THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If after the **Policy** has been in force for [six (6)] months, an **Insured** undergoes a **Routine Examination or Other Preventative Tests**, **We** will pay the applicable amount shown on the Schedule regardless of the number of **Routine Examinations or Other Preventative Tests** undergone by an **Insured**.

For purposes of this rider only, **Routine Examinations or Other Preventative Tests** means annual physical examinations, mammograms, pap smears, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSA's), ultrasounds, and blood screening as prescribed by a **Physician**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy/Certificate** No. \_\_\_\_\_

SERFF Tracking Number: ZURC-127624851 State: Arkansas  
 Filing Company: Zurich American Insurance Company State Tracking Number: 49785  
 Company Tracking Number: CW AH 33353  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Additional Riders For Blanket Accident Insurance For All Other Groups  
 Project Name/Number: /CW AH 33353

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification	Approved	10/28/2011
<b>Comments:</b>		
<b>Attachment:</b>		
U-BMC-300 Certificate of Readability Blanket Affinity & MCM 1.1 Riders.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application	Approved	10/28/2011
<b>Comments:</b>		
The Enrollment Form has been attached under the forms listing.		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved	10/28/2011
<b>Bypass Reason:</b> Not applicable		
<b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Statement of Variables	Approved	10/28/2011
<b>Comments:</b>		
<b>Attachment:</b>		
U-BMC-3001-A AR - Statement of Variables.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Marked up Copy	Approved	10/28/2011
<b>Comments:</b>		
<b>Attachment:</b>		

<i>SERFF Tracking Number:</i>	<i>ZURC-127624851</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>49785</i>
<i>Company Tracking Number:</i>	<i>CW AH 33353</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Additional Riders For Blanket Accident Insurance For All Other Groups</i>		
<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		
U-BMC-303-B AR - Enrollment Form RED 10 27 2011.pdf			

# Certificate of Readability for Arkansas



**Zurich American Insurance Company**

I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-BMC-303-B (08/11)	Enrollment Form	48
U-BMC-310-A (08/11)	[Higher] Education Benefit	47
U-BMC-311-A (08/11)	Common Carrier Benefit	43
U-BMC-313-A (08/11)	Carjacking Benefit	40
U-BMC-314-A (08/11)	Felonious Assault Benefit	43
U-BMC-315-A (08/11)	Rehabilitation Benefit	43
U-BMC-316-A (08/11)	Seat Belt [Air Bag] Benefit	37
U-BMC-321-A (08/11)	Critical Illness Benefit	40
U-BMC-327-A (08/11)	Coma Benefit	52
U-BMC-329-A (08/11)	Emergency Treatment Benefit	42
U-BMC-330-A (08/11)	Funeral Expense Benefit	50
U-BMC-332-A (08/11)	In-Hospital Indemnity Benefit	45
U-BMC-334-A (08/11)	Personal Property Benefit	29
U-BMC-336-A (08/11)	Terrorism Benefit	42
U-BMC-337-A (08/11)	Travel Assistance Program	44
U-BMC-344-A (08/11)	Waiver of Premium for Loss of Employment	45
U-BMC-345-A (08/11)	No Claim Discount	58
U-BMC-346-A (08/11)	Wellness Benefit	38

Although some of the forms listed above may not have achieved the minimum readability standards required by your State Insurance Code, we respectfully request approval based on our belief that:

1. the lower score provides a more accurate reflection of the readability of the form(s); and
2. the lower score is warranted by the nature of the particular form(s) or type or class of form(s).

Signature:   
Officer: Lisa Plante  
Title: Head of A&H Product Management  
Date: August 3, 2011

# Statement of Variables for Arkansas



## **BLANKET ACCIDENT INSURANCE POLICY** **U-BMC-300-A, et al**

This Policy has been developed for use as a Participant Accident policy. Benefits under the policy may be contributory or non-contributory.

Each bracketed benefit or provision will be in or out (in if needed, otherwise omitted.) Each bracketed phrase will be in or out. Eligible persons and Classes will be as defined by the **Policyholder**. [or **Domestic Partner**] will always be in or out.

### **ENROLLMENT FORM – U-BMC-303-B AR (08/11)**

The Enrollment Form will only be used when a Policy is issued as a Voluntary Policy and the Participant's are required to contribute to the cost of premium.

<b>POLICYHOLDER INFORMATION</b> [Master Policy Number:]	This will be in or out.																																																				
<b>ENROLLEE INFORMATION</b> [Certificate Number (assigned by the Company):]	This will be in or out.																																																				
<b>INSURANCE REQUESTED</b> <table border="0"> <thead> <tr> <th><b>[Benefit(s) Included:</b></th> <th><b>Coverage Amount</b></th> </tr> </thead> <tbody> <tr> <td>[Accidental Death Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Accidental Dismemberment Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Exposure and Disappearance Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Accident Weekly Indemnity Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Catastrophe Cash Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Accident Medical Expense Benefit]</td> <td>[as per the Rider]</td> </tr> <tr> <td>[Accident Excess Integrated Medical Expense Benefit]</td> <td>[as per the Rider]</td> </tr> <tr> <td>[Accident Excess Corridor Medical Expense Benefit]</td> <td>[as per the Rider]</td> </tr> <tr> <td>[Heart Failure Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Policyholder Sponsored Activity Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Parent Reimbursement Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Carjacking Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Coma Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Common Carrier Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Critical Illness Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Emergency Treatment Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Felony Assault Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Funeral Expense Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Higher Education Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[In-Hospital Indemnity Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[No Claim Discount]</td> <td>[as per the Rider]</td> </tr> <tr> <td>[Personal Property Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Rehabilitation Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Seat Belt/Air Bag] Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Terrorism Benefit]</td> <td>[as per the Policy Schedule]</td> </tr> </tbody> </table>	<b>[Benefit(s) Included:</b>	<b>Coverage Amount</b>	[Accidental Death Benefit]	[as per the Policy Schedule]	[Accidental Dismemberment Benefit]	[as per the Policy Schedule]	[Exposure and Disappearance Benefit]	[as per the Policy Schedule]	[Accident Weekly Indemnity Benefit]	[as per the Policy Schedule]	[Catastrophe Cash Benefit]	[as per the Policy Schedule]	[Accident Medical Expense Benefit]	[as per the Rider]	[Accident Excess Integrated Medical Expense Benefit]	[as per the Rider]	[Accident Excess Corridor Medical Expense Benefit]	[as per the Rider]	[Heart Failure Benefit]	[as per the Policy Schedule]	[Policyholder Sponsored Activity Benefit]	[as per the Policy Schedule]	[Parent Reimbursement Benefit]	[as per the Policy Schedule]	[Carjacking Benefit]	[as per the Policy Schedule]	[Coma Benefit]	[as per the Policy Schedule]	[Common Carrier Benefit]	[as per the Policy Schedule]	[Critical Illness Benefit]	[as per the Policy Schedule]	[Emergency Treatment Benefit]	[as per the Policy Schedule]	[Felony Assault Benefit]	[as per the Policy Schedule]	[Funeral Expense Benefit]	[as per the Policy Schedule]	[Higher Education Benefit]	[as per the Policy Schedule]	[In-Hospital Indemnity Benefit]	[as per the Policy Schedule]	[No Claim Discount]	[as per the Rider]	[Personal Property Benefit]	[as per the Policy Schedule]	[Rehabilitation Benefit]	[as per the Policy Schedule]	[Seat Belt/Air Bag] Benefit]	[as per the Policy Schedule]	[Terrorism Benefit]	[as per the Policy Schedule]	This entire section will be in or out. If in: Any combination of Benefits may be in or out;
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[Travel Assistance Program]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]	
[Wellness Benefit]	[\$ ] [in increments of [\$25] not to exceed [\$1,000]]	
[ ]	[ ]	Additional Benefit(s) and Coverage Amounts may be included as filed and approved by the State.



**[HIGHER] EDUCATION BENEFIT – U-BMC-310-A CW (08/11)**

If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:

[\$10,000] per **Dependent Child**

If the **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Benefit, **We** will pay an additional benefit for [higher] education expenses incurred for each **Dependent Child**.

[A **Dependent Child** is eligible for the [Higher] Education Benefit if on the date of the **Covered Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Covered Accident**.]

The [Higher] Education Benefit will be equal to the amount shown on the Schedule per **Dependent Child**.

[This amount will be paid annually for up to [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of [higher] learning on a full-time basis.]

[If, at the time of the **Covered Accident**, there are no **Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [\$1,000] to the designated beneficiary.]

For purposes of this rider only, **Dependent Child(ren)** means those unmarried **Dependent Child(ren)** of the **Insured**, [and] [those unmarried **Dependent Child(ren)** of his or her **Spouse[/Domestic Partner]]** who rely on the **Insured** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

[\$10,000] The range will be \$1,000 - \$50,000

[higher] will be in or out.

This section will be in or out. If in:  
[Higher] will be in or out.

[Higher] will be in or out.

This section will be in or out. If in:  
[four (4)] The range will be 1 - 6

[higher] will be in or out.

This section will be in or out. If in:

[\$1,000] The range will be \$500 - \$5,000.

[and] will be in or out.  
[those unmarried **Dependent Child(ren)** of his or her **Spouse[/Domestic Partner]]** will be in or out. If in:  
[**Domestic Partner**] will be in or out.  
[more than 50% of] will be in or out.  
[19 (nineteen)] The range will be 18 - 30  
[25 (twenty-five)] The range will be 18 – 30

[not] will be in or out.

**COMMON CARRIER BENEFIT – U-BMC-311-A CW (08/11)**

If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:

[\$50,000]

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit, **We** will pay an additional benefit equal to the amount in the Schedule, provided the **Insured** suffers the **Covered Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit only, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire; and
2. any civilian aircraft that holds a certificate of Public Conveyance and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

[\$50,000] The range will be \$1,000 - \$1,000,000

[Accidental Death] will be in or out.

[and] will be in or out.

[Accidental Dismemberment] will be in or out.

[not] will be in or out.

**CARJACKING BENEFIT – U-BMC-313-A CW (08/11)**

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[\$10,000]</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b>, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit, as a direct result of a <b>Covered Accident</b> that occurs during a <b>Carjacking</b> of a private passenger vehicle that the <b>Insured</b> was operating, getting into or out of, or riding in as a passenger, <b>We</b> will pay an additional benefit equal to the amount shown on the Schedule.</p> <p>Verification of the <b>Carjacking</b> must be made part of an official police report within [twenty-four (24) hours] of the <b>Carjacking</b> or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24 ) hours] or as soon as reasonably possible, and such verification must be provided to <b>Us</b>.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[\$10,000] The range will be \$1,000 - \$50,000</p> <p>[Accidental Death] will be in or out. [and] will be in or out. [Accidental Dismemberment] will be in or out.</p> <p>[twenty-four (24) hours] The range will be 12 - 48</p> <p>[twenty-four (24) hours] The range will be 12 - 48</p> <p>[not] will be in or out.</p>
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**FELONIOUS ASSAULT BENEFIT – U-BMC-314-A CW (08/11)**

If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:

[15%] of the Coverage Amount for the [Accidental Death]  
[Accidental Dismemberment] Benefit

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit as a result of a violent or criminal act committed by someone other than the **Insured**, [a **Fellow Employee**] or a member of his or her **Family** or **Household**, **We** will pay an additional benefit equal to the amount shown on the Schedule.

For purposes of this rider only, the following additional definitions apply:

**[Fellow Employee]** means a person employed by the same employer as the **Insured** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the defined violent crime/felonious assault was committed.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy/Certificate**.

[15%] The range will be 5% - 50%  
[Accidental Death] will be in or out.  
[Accidental Dismemberment] will be in or out.

[Accidental Death] will be in or out.  
[and] will be in or out.  
[Accidental Dismemberment] will be in or out.  
[a **Fellow Employee**] will be in or out.

This will be in or out. If in:

[forty-five (45)] The range will be 10 - 90.

[not] will be in or out.

## REHABILITATION BENEFIT – U-BMC-315-A CW (08/11)

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>Up to a maximum of [\$10,000]</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b>, which is payable under the [Accidental Dismemberment] Benefit, <b>We</b> will pay an additional benefit for the <b>Reasonable and Customary</b> expenses actually incurred for <b>Rehabilitation Training</b>, in an amount equal to the lesser of:</p> <ol style="list-style-type: none"> <li>1. the actual expenses that are incurred within [two (2) years] from the date of the <b>Covered Accident</b> for the <b>Rehabilitation Training</b>; or</li> <li>2. the maximum amount shown in the Schedule.</li> </ol> <p>For purposes of this rider only, the following additional definitions apply:</p> <p><b>Pre-existing Condition</b> means a condition for which a <b>Insured</b> received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [6] months immediately preceding the <b>Covered Loss</b>.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[\$10,000] The range will be \$1,000 - \$50,000</p> <p>[Accidental Dismemberment] may be replaced with another Benefit.</p> <p>[two (2) years] The range will be 6 months – 4 years</p> <p>[6] The range will be 6 - 12.</p> <p>[not] will be in or out.</p>
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## SEAT BELT[AIR BAG] BENEFIT – U-BMC-316-A CW (08/11)

If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:

Seat Belt – [[10%] of the Coverage Amount for the [Accidental Death] [Accidental Dismemberment] Benefit to a maximum of [\$10,000]] [\$10,000]

[Air Bag - [[10%] of the Coverage Amount for the [Accidental Death] [Accidental Dismemberment] Benefit to a maximum of [\$10,000]] [\$10,000]]

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and] [Accidental Dismemberment] Benefit, and the **Covered Injury** [which caused the **Accidental** death] directly resulted from a motor vehicle **Covered Accident**, **We** will pay an additional Seat Belt Benefit, which equals the amount shown on the Schedule, provided that the **Insured** was:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the **Insured's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the motor vehicle **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional Air Bag Benefit equal to the amount shown on the Schedule, will be paid if the **Insured** was driving a private passenger motor vehicle with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger motor vehicle with a manufacturer equipped passenger-side air bag, provided the **Insured's** seat belt or lap and shoulder restraint was properly fastened at the time of the motor vehicle **Covered Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the motor vehicle **Covered Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a Seat Belt [or Air Bag] Benefit to the **Insured** that was driving either:

1. under the influence of alcohol:
  - a. An **Insured** will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the motor vehicle **Covered Accident** occurred;

[10%] The range will be 5% - 50%  
[Accidental Death] will be in or out.  
[Accidental Dismemberment] will be in or out.  
[\$10,000] The range will be \$1,000 - \$100,000  
[\$10,000] The range will be \$1,000 - \$100,000

The Air Bag Benefit will be in or out. If in:  
[10%] The range will be 5% - 50%  
[Accidental Death] will be in or out.  
[Accidental Dismemberment] will be in or out.  
[\$10,000] The range will be \$1,000 - \$100,000  
[\$10,000] The range will be \$1,000 - \$100,000

[Accidental Death] will be in or out.  
[and] will be in or out.  
[Accidental Dismemberment] will be in or out.  
[which caused the **Accidental** death] will be in or out.

The Air Bag Benefit will be in or out.

This provision will be in or out. If in:  
[or **Air Bag**] will be in or out.

<p>b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or</p> <p>2. under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a <b>Physician</b> and taken in accordance with the prescribed dosage.]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[not] will be in or out.</p>
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## CRITICAL ILLNESS BENEFIT - U-BMC-321-A AR (08/11)

If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:

[Coverage Amount for:

[Cancer: [\$50,000]]  
 [Heart Attack: [\$50,000]]  
 [Kidney Failure: [\$50,000]]  
 [Loss of Limb(s) : [\$50,000]]  
 [Major Organ Transplant: [\$50,000]]  
 [Paralysis: [\$50,000]]  
 [Stroke: [\$50,000]]]

2. **Coverage Amount** - The **Coverage Amount** is that amount shown on the Schedule and will be reduced as described below:

a. The **Coverage Amount** will be reduced to [50] percent of the **Coverage Amount** when the **Insured** reaches age [65].

b. If the sum of the **Coverage Amounts** on this and any other Critical Illness Benefit or Critical Illness Policy issued by **Us** on the life of the **Insured** exceeds [\$250,000], the **Coverage Amount** for each such Benefit and Policy will be decreased proportionately such that the sum of the **Coverage Amounts** becomes [\$250,000] before any claim is paid. **We** will adjust the premiums for such Benefits and Policies and refund to the **Insured** the excess of premiums already paid over the premiums that should have been paid for the new **Coverage Amount**, without interest.]

**[Cancer/Cancerous** is a malignant neoplasm (including lymphatic and hematological malignancy) characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. To qualify for the **Coverage Amount**, the **Diagnosis** of **Cancer** must be supported by histological evidence of malignancy, must be made by a Pathologist **Physician**, and the **Cancer** must first occur after a [thirty (30)-day] **Waiting Period**. Clinical Diagnosis of Cancer shall be accepted as evidence that cancer exists when a pathological diagnosis is medically inappropriate.

Excluded from coverage are:

- a. Benign tumors or polyps that are histologically described as non-malignant, pre-malignant or non-invasive.
- b. All tumors, benign or malignant, in the presence of HIV infection.
- c. All skin Cancers with the exception of invasive melanoma classified as Clark level II or higher or having a thickness measured in excess of 0.75mm.
- d. Carcinoma in situ (defined as being in position and not extending beyond the focus or level of origin).
- e. All tumors of the prostate, unless having progressed to at least TNM classification T2N0M0 or histologically classified as having a Gleason score greater than 6.
- f. Chronic Lymphocytic Leukemia (CLL) unless Rai Stage 3 or greater.

This will be in or out. If in, any combination may be included:

If in, the range will be \$1,000 - \$1,000,000;  
 If in, the range will be \$1,000 - \$1,000,000;  
 If in, the range will be \$1,000 - \$1,000,000;  
 If in, the range will be \$1,000 - \$1,000,000;  
 If in, the range will be \$1,000 - \$1,000,000;  
 If in, the range will be \$1,000 - \$1,000,000;  
 If in, the range will be \$1,000 - \$1,000,000.

The range will be 5% - 100%.

The range will be from age 50 - 85.

This will be in or out. If in:

The range will be \$1,000 - \$1,000,000.

The range will be \$1,000 - \$1,000,000.

This will be in or out. If in:

The range will be 10 to 30 days.

<p>g. Papillary microinvasive Cancer of the thyroid, bladder, cervix, or breast.]</p> <p><b>[Heart Attack (Myocardial Infarction)</b> is the death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply. To qualify for the <b>Coverage Amount</b>, the <b>Diagnosis</b> of a <b>Heart Attack</b> must be made by a <b>Physician</b> and the <b>Heart Attack</b> must first occur after a [30-day] <b>Waiting Period</b>. The <b>Diagnosis</b> must be supported by all of the following:</p> <ul style="list-style-type: none"> <li>a. A history consistent with <b>Heart Attack</b>;</li> <li>b. New electrocardiogram (EKG) changes demonstrating significant Q waves (duration greater than or equal to .04 seconds and a depth greater than or equal to 5 mm) or loss of R waves diagnostic of a <b>Heart Attack</b>;</li> <li>c. Elevation of cardiac enzymes, including CPK-MB and troponin; and</li> <li>d. If performed, nuclear imaging scan or echocardiogram consistent with <b>Myocardial Infarction</b>.</li> </ul> <p>[Excluded from coverage are: All other heart disorders, including but not limited to: congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, and all other dysfunctions of the cardiovascular system, unless also accompanied by a <b>Heart Attack</b> as defined above.]]</p> <p><b>[Kidney Failure</b> is the chronic and irreversible failure of both kidneys to excrete metabolites or retain electrolytes. To qualify for the <b>Coverage Amount</b>, the <b>Diagnosis</b> of <b>Kidney Failure</b> must be made by a Nephrological <b>Physician</b>. The <b>Kidney Failure</b> must require either chronic dialysis or transplantation and must first occur after a [30-day] <b>Waiting Period</b>.]</p> <p><b>[Loss of Limb(s)</b> - The loss of one or more limbs (arms or legs) as a result of a <b>Covered Injury</b>. To qualify for the <b>Coverage Amount</b>, the <b>Loss of Limb(s)</b> must involve complete and permanent severance of one or more limbs through or above the elbow or knee joint. The <b>Loss of Limb(s)</b> must be uncorrectable by surgery or any other means. [Excluded from coverage is: <b>Loss of Limb(s)</b> due to a disease process.]]</p> <p><b>[Major Organ Transplant</b> is the receipt by transplant of human bone marrow or an entire human heart, kidney, lung, pancreas or liver. To qualify for the <b>Coverage Amount</b>, the <b>Major Organ Transplant</b> must be performed by a <b>Physician</b> and must first occur after a [30-day] <b>Waiting Period</b>.]</p> <p><b>[Paralysis</b> is the loss of motor function due to neurological injury. To qualify for the <b>Coverage Amount</b>, the <b>Diagnosis</b> of <b>Paralysis</b> must be made by a Neurological <b>Physician</b>. There must be complete and permanent loss of use of both legs (complete paraplegia or quadriplegia) through neurological trauma or <b>Accident</b> to the spinal cord. The <b>Paralysis</b> must have been present for a continuous period of at least [90] days. To qualify for the <b>Coverage Amount</b>, the</p>	<p>This will be in or out. If in,:</p> <p>The range will be 10 to 30 days.</p> <p>This will be in or out.</p> <p>This will be in or out. If in:</p> <p>The range will be 5 to 30 days.</p> <p>This will be in or out. If in:</p> <p>This will be in or out.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 30 days.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 180 days. The range will be 10 to 30 days.</p>
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<p><b>Paralysis</b> must first occur after a [30-day] <b>Waiting Period</b>.]  [Excluded from coverage is <b>Paralysis</b> resulting from any neurological disease, including but not limited to, Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS).]]</p> <p><b>[Stroke (Cerebrovascular Accident)</b> is the sudden loss of neurological function due to an ischemic or hemorrhagic intracranial vascular event. To qualify for the <b>Coverage Amount</b>, the <b>Diagnosis of Stroke</b> must be made by a <b>Physician</b> and the <b>Stroke</b> must first occur after a [30-day] <b>Waiting Period</b>. The <b>Stroke</b> must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [30] days and be verified by computed tomography (CT) scan or magnetic resonance imaging (MRI).  [Excluded from coverage are:</p> <ol style="list-style-type: none"> <li>a. Neurological symptoms due to transient ischemic attack (TIA);</li> <li>b. Brain injury resulting from trauma or generalized anoxia (hypoxia); and</li> <li>c. Vascular disease affecting the eye, optic nerve, or vestibular function.]]</li> </ol> <p>5. <b>[Preexisting Condition</b> means a condition for which symptoms existed within [two years] prior to the later of the effective date of this Critical Illness Benefit or the effective date of reinstatement. If the <b>Insured</b> is <b>Diagnosed</b> with a <b>Covered Condition</b> that is determined by a <b>Physician</b> at <b>Our</b> expense to be a <b>Preexisting Condition</b>, no Critical Illness Benefit is payable for that <b>Covered Condition</b> until twelve (12) months after the effective date of coverage under this Rider.]</p> <p>7. Payment of the <b>Coverage Amount</b> is subject to all of the following conditions:</p> <ol style="list-style-type: none"> <li>a. The sum of the <b>Coverage Amounts</b> payable under this Critical Illness Benefit and any other Critical Illness Benefit or Critical Illness Policy issued by <b>Us</b> on the life of the <b>Insured</b> may not exceed [\$250,000].</li> </ol> <p>8. Exclusions and Limitations  [a.; b.; c. i, ii, iii]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>This will be in or out.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 180 days.</p> <p>The range will be 10 to 180 days.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>The range will be \$1,000 to \$1,000,000.</p> <p>Exclusions:  any combination may be in or out.</p> <p>[not] will be in or out.</p>
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## COMA BENEFIT - U-BMC-327-A AR (08/11)

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[10%] of the Coverage Amount for the [Accidental Death] [Accidental Dismemberment] Benefit</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b> within [365] days of a <b>Covered Accident</b>, and such <b>Covered Injury</b> causes the <b>Insured</b> to be in a <b>Coma</b>, <b>We</b> will pay a Coma Benefit.</p> <p>The Coma Benefit is equal to the amount shown on the Schedule and will be paid each month the <b>Insured</b> remains in a <b>Coma</b>.</p> <p>[The Coma Benefit will be payable per the Schedule per month for the first [eleven (11)] months the <b>Insured</b> remains in a <b>Coma</b>. At the end of the [eleven (11)] months of payment, if the <b>Insured</b> remains in a <b>Coma</b>, <b>We</b> will pay a lump sum benefit equal to the <b>Principal Sum</b> payable under the Accidental Death Benefit less the amount of the [eleven (11)] months of benefit already received.]</p> <p>The Coma Benefit will end on the earliest of the following:</p> <ol style="list-style-type: none"> <li>1. the date the <b>Insured</b> is no longer in a <b>Coma</b> that resulted directly from the <b>Covered Injury</b>; or</li> <li>2. the <b>Insured</b> has received the full Coma Benefit for [11] months.</li> </ol> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[10%] The range will be 1% - 100% [Accidental Death] will be in or out. [Accidental Dismemberment] will be in or out.</p> <p>[365] The range will be 90 - 730 days.</p> <p>The total Coma Benefit amount will not exceed one times the <b>Principal Sum</b> payable per the Schedule. The range will be 1% - 100% of the <b>Principal Sum</b>.</p> <p>This will be in or out. If in:  [eleven (11)] The range will be 11 - 24.  [eleven (11)] The range will be 11 - 24.</p> <p>[11] The range will be 11 - 24.</p> <p>[11] The range will be 1 - 100.</p> <p>[not] will be in or out.</p>
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## EMERGENCY TREATMENT BENEFIT - U-BMC-329-A CW (08/11)

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[\$500.00] [The maximum number of Emergency Treatment Benefits payable per calendar year per <b>Insured</b> is [2]]</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> that results in a <b>Covered Loss</b> and, within [forty-eight (48)] hours of the <b>Covered Accident</b>, is required to receive <b>Medically Necessary Emergency Treatment</b> [in the emergency room of a <b>Hospital</b>], <b>We</b> will pay the amount shown on the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one <b>Covered Accident</b> per <b>Insured</b>. [The maximum number of Emergency Treatment Benefits payable per calendar year per <b>Insured</b> regardless of the number of <b>Covered Accidents</b> incurred, is shown on the Schedule.]</p> <p><b>[Hospital]</b> means an institution which:</p> <ol style="list-style-type: none"> <li>1. operates pursuant to law;</li> <li>2. primarily and continuously provides medical care and treatment to sick and injured persons on an in-patient basis;</li> <li>3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of <b>Physicians</b>; and</li> <li>4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).</li> </ol> <p><b>Hospital</b> does not mean any institution or part thereof which is used primarily as:</p> <ol style="list-style-type: none"> <li>1. a nursing home, convalescent home, or skilled nursing facility;</li> <li>2. a place of rest, custodial care, or for the aged;</li> <li>3. a clinic; or</li> <li>4. a place for the treatment of mental illness, alcoholism, or substance abuse.</li> </ol> <p>However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a <b>Hospital</b> if it is:</p> <ol style="list-style-type: none"> <li>1. part of the institution that meets the above requirements; and</li> <li>2. listed in the American Hospital Association Guide as a general <b>Hospital</b>.] <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p> </li></ol>	<p>The range will be \$100.00 - \$10,000.00. This will be in or out. If in, the range is 1 - 10.</p> <p>[48] The range will be 24 - 120.</p> <p>[in the emergency room of a <b>Hospital</b>] This will be in or out. The standard amount shown on the Schedule will be \$500.00 and the range will be \$100.00 - \$10,000.00. [, the largest,] This will be in or out. [The maximum number... Schedule.] This will be in or out. If in, the range will be one (1) to ten (10).</p> <p>This will be in or out.</p> <p>[not] will be in or out.</p>
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**FUNERAL EXPENSE BENEFIT - U-BMC-330-A CW (08/11)**

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[\$1,000.00]</p> <p>If an <b>Insured</b> sustains a <b>Covered Injury</b> that results in a <b>Covered Loss</b> payable under the [Accidental Death] Benefit, <b>We</b> will pay an additional Funeral Expense Benefit equal to the amount shown on the Schedule].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>The range will be \$1,000 to \$100,000.</p> <p>[Accidental Death] This may be replaced with other benefits that include an Accidental Death Benefit. The range will be \$1,000 to \$100,000.</p> <p>[not] will be in or out.</p>
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## IN-HOSPITAL INDEMNITY BENEFIT - U-BMC-332-A AR (08/11)

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[\$100] per [day] for a maximum of [twelve (12)] months and the total payment amount will not exceed the Coverage Amount for the [Accidental Death] [Accidental Dismemberment] Benefit</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b> that requires <b>Hospital Confinement</b> for more than [seven (7)] consecutive days, <b>We</b> will pay the amount shown on the Schedule for a maximum of [twelve (12)] months for any <b>Covered Injury</b>. To be eligible for this benefit, the initial <b>Hospital Confinement</b> period must begin within [ninety (90)] days of the <b>Covered Injury</b>.</p> <p>Successive periods of <b>Hospital Confinement</b> arising out of the same <b>Covered Injury</b> will be considered one confinement only if they are separated by a period of less than [three (3)] months.</p> <p><b>Hospital Confinement</b> means admission to a <b>Hospital</b> as an inpatient for at least [twenty-four (24)] consecutive hours</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[\$100] The range will be \$100 - \$1,000  [day] This may be week or month.  [twelve (12)] The range will be 12 - 24.  [Accidental Death] will be in or out.  [Accidental Dismemberment] will be in or out.</p> <p>[seven (7)] The range will be 1 - 30.  [twelve (12)] The range will be 12 - 24.</p> <p>[ninety (90)] The range will be 1 - 365.</p> <p>The range will be 1 - 5</p> <p>The range will be 24 - 48.</p> <p>[not] will be in or out.</p>
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**PERSONAL PROPERTY BENEFIT – U-BMC-334-A CW (08/11)**

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[\$5,000] [after satisfaction of the [\$100] Deductible per <b>Covered Accident</b>]</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> requiring emergency medical attention by a <b>Physician</b> resulting in a <b>Covered Loss</b> as a result of a <b>Covered Accident</b> and due to that same <b>Covered Accident</b> the <b>Insured</b> sustains a loss or destruction to <b>Personal Property</b>, <b>We</b> will pay a benefit [after satisfaction of the Deductible per <b>Covered Accident</b>] up to the amount shown on the Schedule [provided <b>We</b> receive an incident report from a police or security authority].</p> <p>[<b>We</b> will require valid receipts of replacement <b>Personal Property</b> prior to payment of any benefits.]</p> <p><b>Personal Property</b> includes but is not limited to the following items [that are originally issued by a [police][fire][security] department and for which the <b>Insured</b> is financially responsible to return or replace]: clothing, musical instruments, cameras, jewelry, watches, furs, radios, [uniform, radio, baton, cuffs, protective vest, handgun, helmet, boots, and other similar items that would typically accompany a [[police][security officer][fireman] in his or her daily duties].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[\$5,000] The range will be \$50 to \$5,000. This will be in or out. If in: [\$100] The range will be \$0 - \$500</p> <p>[after satisfaction of the Deductible per <b>Covered Accident</b>] will be in or out. [provided <b>We</b> receive an incident report from a police or security authority] will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. If in, [police][fire][security] will be in or out.</p> <p>[uniform, radio, baton, cuffs, protective vest, handgun, helmet, boots, and other similar items that would typically accompany a [police][security officer][fireman] in his or her daily duties] This will be in or out.</p> <p>[not] will be in or out.</p>
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**TERRORISM BENEFIT - U-BMC-336-A CW (08/11)**

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[[10%] of the Coverage Amount for the [Accidental Death] Benefit to a maximum of [\$10,000]] [\$10,000]</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b>, which is payable under the [Accidental Death] Benefit, that was directly caused by an <b>Act of Terrorism</b> [within the <b>United States</b>] [outside of the <b>United States</b>], <b>We</b> will pay an additional benefit equal to the amount shown on the Schedule.</p> <p><b>We</b> may cancel this Terrorism Benefit by sending the <b>Policyholder</b> at their most recent address in <b>Our</b> records, a [ten (10)] day notice of <b>Our</b> intent to cancel.</p> <p>[<b>United States</b> means the United States of America [including] [excluding] its territories, possessions, and protectorates.]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>[10%] The range will be 10% - 100% [Accidental Death] This may be replaced with other benefits that include an Accidental Death Benefit. [\$10,000] The range will be \$1,000 - \$100,000 [\$10,000] The range will be \$1,000 - \$100,000</p> <p>[Accidental Death] This may be replaced with other benefits that include an Accidental Death Benefit. [within the <b>United States</b>] will be in or out. [outside of the <b>United States</b>] will be in or out. If both [within...] and [outside...] are out, the coverage is worldwide.</p> <p>[ten (10)] The range will be 10 - 180 days.</p> <p>This will be in or out. If in, [including] [excluding] will be in or out.</p> <p>[not] will be in or out.</p>
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## TRAVEL ASSISTANCE PROGRAM - U-BMC-337-A CW (08/11)

If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:

[The maximum amount payable is as follows:

[Medical Evacuation: [\$5,000]]  
 [Medical Repatriation: [\$5,000]]  
 [Non-Medical Repatriation: [\$5,000]]  
 [Return of Remains: [\$5,000]]  
 [Visit to Hospital: [\$5,000]]  
 [Return of Child: [\$5,000]]  
 [Return of Companion: [\$5,000]]]

This Travel Assistance Program will apply to an **Insured** when he or she is traveling [100] mile(s) or more from their **Principal Residence**:

### MEDICAL EVACUATION

[in accordance with **Western Medical Standards**]  
 [The maximum amount **We** will pay for Medical Evacuation is equal to the amount shown on the Schedule.]

### MEDICAL REPATRIATION

[The maximum amount **We** will pay for Medical Repatriation is shown on the Schedule].

### NON-MEDICAL REPATRIATION

[The maximum amount **We** will pay for Non-Medical Repatriation is shown on the Schedule].

### RETURN OF REMAINS

[The maximum amount **We** will pay for Return of Remains is shown on the Schedule].

### VISIT TO HOSPITAL

If an **Insured** is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We**...

[The maximum amount **We** will pay for Visit to Hospital is shown on the Schedule].

### RETURN OF CHILD

If an **Insured** is traveling with [a] **Dependent Child(ren)**, who [is][are] under [nineteen (19)] years of age or [a] **Dependent Child(ren)** who prior to age [nineteen (19)] became...

[The maximum amount **We** will pay for Return of Child is shown on the Schedule].

### RETURN OF COMPANION

[The maximum amount **We** will pay for Return of Companion is shown on the Schedule].

### TRAVEL ASSISTANCE PROGRAM EXCLUSIONS

This will be in or out. If in, any combination may be included:

If in, the range will be \$5,000 - \$1,000,000;  
 If in, the range will be \$5,000 - \$1,000,000;  
 If in, the range will be \$5,000 - \$1,000,000;  
 If in, the range will be \$5,000 - \$1,000,000;  
 If in, the range will be \$5,000 - \$1,000,000;  
 If in, the range will be \$5,000 - \$1,000,000;  
 If in, the range will be \$5,000 - \$1,000,000.

[100] The range will be 1 - 1,000.

This will be in or out.

This will be in or out.

This will be in or out.

This will be in or out.

This will be in or out.

[seven (7)] The range will be 2 - 30.

This will be in or out.

[nineteen (19)] The range will be 18 - 30.

[nineteen (19)] The range will be 18 - 30.

This will be in or out.

This will be in or out.

All Exclusions will be in unless noted otherwise. The following will be in or out:

<p>For purposes of this rider only, the following additional definitions apply:</p> <p><b>Covered Trip</b> means when an <b>Insured</b> is traveling more than [100] miles...</p> <p><b>Dependent Child(ren)</b> means those unmarried <b>Dependent Child(ren)</b> of the <b>Insured</b>, [and] [those unmarried <b>Dependent Child(ren)</b> of his or her <b>Spouse[/Domestic Partner]</b>] who rely on the <b>Insured</b> for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.</p> <p><b>[Western Medical Standards</b> means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.]</p> <p><b>TRAVEL ASSISTANCE PROGRAM – OTHER PROVISIONS</b></p> <p>[Excess Coverage  <b>Our</b> obligation to pay the <b>Policyholder</b> or <b>Insured</b> under this Travel Assistance Program will be excess of any other insurance which the <b>Policyholder</b> or <b>Insured</b> has with respect to the expenses covered under this Travel Assistance Program.]</p> <p>Reservation of Rights  <b>We</b> reserve the right to suspend, curtail or limit <b>Our</b> coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit <b>Us</b> to provide services [or in any country for which a travel warning has been issued by the Department of State of the United States of America].</p> <p>[Exempted Countries  This Travel Assistance Program is not available in the following countries: [Iran]. <b>We</b> further reserve <b>Our</b> rights to modify this list upon [ten (10)] days notice to the <b>Policyholder</b>.]</p> <p>Scope  [Covered transportation expenses will be limited to air and marine conveyance.]  [To contact <b>Us</b> regarding this Travel Assistance Program, the <b>Insured</b> must call [1-800-263-0261] from the U.S. or Canada; and collect from anywhere else in the world at [+1-416-977-0277].]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>2.;3.; 8.</p> <p>[100] The range will be 1 - 1,000.</p> <p>[and] will be in or out.  [those unmarried <b>Dependent Child(ren)</b> of his or her <b>Spouse[/Domestic Partner]</b>] will be in or out. If in: <b>[/Domestic Partner]</b> will be in or out.  [more than 50% of] will be in or out.  [19 (nineteen)] The range will be 18 - 30  [25 (twenty-five)] The range will be 18 – 30</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. If in:  [Iran] This list could include multiple countries.  [ten (10)] The range will be 10 - 90.</p> <p>This will be in or out.</p> <p>This will be in or out. If in, the telephone numbers would be updated as necessary.</p> <p>[not] will be in or out.</p>
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**WAIVER OF PREMIUM DUE TO UNEMPLOYMENT - U-BMC-344-A CW (08/11)**

<p>If an <b>Insured</b> becomes <b>Unemployed</b> while covered under this <b>Policy</b>, <b>We</b> will waive the premium due from him or her under this <b>Policy</b>, provided the <b>Unemployment</b> continues for a period greater than [180] consecutive days. Premium payments must continue for the first [180] days of the continuous <b>Unemployment</b>. After the initial [180] day period of continuous <b>Unemployment</b>, the <b>Insured's</b> premium for this <b>Policy</b> will be waived until the earliest of the following:</p> <ol style="list-style-type: none"><li>1. the <b>Insured</b> is no longer <b>Unemployed</b>;</li><li>2. the <b>Policy</b> terminates;</li><li>3. [60] days expired since the Waiver of Premium was granted by <b>Us</b>.</li><li>4. [the <b>Insured</b> attains age [70]].</li></ol> <p>For purposes of this rider only, <b>Unemployed/Unemployment</b> means that the <b>Insured</b> was a full-time employee for a continuous period of [180] days immediately prior to the request for Waiver of Premium and was involuntarily discharged from that employment and is registered for <b>Unemployment</b> benefits with the appropriate government employment agency.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>The range will be 90 to 180 days. The range will be 90 to 180 days.</p> <p>The range will be 90 to 180 days.</p> <p>3. The range will be 30 to 180 days.</p> <p>4. This will be in or out. If in, the range will be age 50 to 85.</p> <p>The range will be 90 to 180 days.</p> <p>[not] will be in or out.</p>
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**NO CLAIM DISCOUNT – U-BMC-345-A CW (08/11)**

<p>If after the <b>Insured's</b> coverage under the <b>Policy</b> has been in force for [three (3)] years, and no claim has been filed or paid under the <b>Policy</b>, [except for Wellness Benefits,] the <b>Insured</b> is entitled to a <b>No Claim Discount</b>.</p> <p>For purposes of this rider only, a <b>No Claim Discount</b> means a one-time premium reduction of [10%] off the annual premium as stated on the Schedule. The <b>No Claim Discount</b> will become effective on the next renewal term and will remain in effect for each subsequent [anniversary] [renewal term] until such time as a claim may be filed or paid.</p>	<p>The range will be 1 to 5 years. This will be in or out.</p> <p>The range will be 1% to 10%.</p> <p>[anniversary] will be in or out. [renewal term] will be in or out.</p>
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WELLNESS BENEFIT - U-BMC-346-A CW (08/11)

<p>If this Benefit is included, the Policy Schedule will be revised to include the following Coverage Amount:</p> <p>[\$50]</p> <p>If after the <b>Policy</b> has been in force for [six (6)] months, an <b>Insured</b> undergoes a <b>Routine Examination or Other Preventative Tests</b>, <b>We</b> will pay the applicable amount shown on the Schedule regardless of the number of <b>Routine Examinations or Other Preventative Tests</b> undergone by an <b>Insured</b>.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy/Certificate</b>.</p>	<p>The range will be \$50 - \$1,000</p> <p>The range will be 1 - 6 months.</p> <p>[not] will be in or out.</p>
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# Enrollment Form

## Blanket Accident Insurance



**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of <b>Policyholder</b> :	[Master Policy Number:]

ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):		Last 4 Digits of SSN: XXX-XX-	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -
Requested Effective Date (MM/DD/YYYY):		[Certificate Number (assigned by the Company): ]	

PARENT OR LEGAL GUARDIAN INFORMATION (if Enrollee is a Minor)			
Full Legal Name (First, Middle Initial and Last):		Relationship to Enrollee: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -

INSURANCE REQUESTED	
[Benefit(s) Included:]	Coverage Amount
[Accidental Death Benefit]	[as per the Policy Schedule]
[Accidental Dismemberment Benefit]	[as per the Policy Schedule]
[Exposure and Disappearance Benefit]	[as per the Policy Schedule]
[Accident Weekly Indemnity Benefit]	[as per the Policy Schedule]
[Catastrophe Cash Benefit]	[as per the Policy Schedule]
[Accident Medical Expense Benefit]	[as per the Rider]
[Accident Excess Integrated Medical Expense Benefit]	[as per the Rider]
[Accident Excess Corridor Medical Expense Benefit]	[as per the Rider]
[Heart Failure Benefit]	[as per the Policy Schedule]
[Policyholder Sponsored Activity Benefit]	[as per the Policy Schedule]
[Parent Reimbursement Benefit]	[as per the Policy Schedule]



<input type="checkbox"/> [Common Carrier Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Critical Illness Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Emergency Treatment Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Felony Assault Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Funeral Expense Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Higher Education Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [In-Hospital Indemnity Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Personal Property Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Rehabilitation Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Seat Belt/Air Bag] Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Terrorism Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Travel Assistance Program]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Wellness Benefit]	[\$ ] [in increments of \$25] not to exceed \$1,000]]
<input type="checkbox"/> [ ]	[ ]]

#### **[CRITICAL ILLNESS BENEFIT QUESTIONNAIRE**

1. Has the Enrollee ever been diagnosed with or treated for any of the following ( <i>Oregon residents only</i> : during the past ten (10) years):		
a. heart attack, angina, high blood pressure, chest pains, disease or disorder of the heart or circulatory system, diabetes?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?	<input type="checkbox"/> YES	<input type="checkbox"/> NO]
2. Has the Enrollee ever tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or treated for acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Has the Enrollee ever been advised of the need for a transplant, been evaluated for a transplant and/or currently on a transplant waiting list?	<input type="checkbox"/> YES	<input type="checkbox"/> NO]

#### **BENEFICIARY DESIGNATION**

##### **Primary Beneficiary:**

Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
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Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
<b>Contingent Beneficiary:</b>		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

<b>PREMIUM INFORMATION:</b>	
Enrollee:	[\$0.000] [per \$[1,000] of <b>Principal Sum</b> ] [per month]
[Annual Premium Option:	[\$40.00]]
Frequency of Payment: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	
Method of Payment: <input type="checkbox"/> Credit Card <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/> Agency Bill [The Enrollee, or if the Enrollee is a minor, the Enrollee's Parent or Legal Guardian, must complete a separate authorization form for a [Credit Card] [or] [Bank Draft] payment.	

### INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Enrollee hereby enrolls for Accident Insurance and ~~declares~~ represents that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

### It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic):

Date:

Parent or Legal Guardian's Signature (may be electronic):

Date:

<b>[AGENT INFORMATION]</b>	
Name of Agent:	Agent's State License Number:
Agent's Signature:	[Producer Number:     ]]

<i>SERFF Tracking Number:</i>	<i>ZURC-127624851</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>49785</i>
<i>Company Tracking Number:</i>	<i>CW AH 33353</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Additional Riders For Blanket Accident Insurance For All Other Groups</i>		
<i>Project Name/Number:</i>	<i>/CW AH 33353</i>		

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
09/14/2011	Form	Enrollment Form Blanket Accident Insurance	10/28/2011	U-BMC-303-B AR - Enrollment Form.pdf (Superseded)

# Enrollment Form

## Blanket Accident Insurance



**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of <b>Policyholder</b> :	[Master Policy Number:]

ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):		Last 4 Digits of SSN: XXX-XX-	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married [ <input type="checkbox"/> Domestic Partner]	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -
Requested Effective Date (MM/DD/YYYY):		[Certificate Number (assigned by the Company): ]	

PARENT OR LEGAL GUARDIAN INFORMATION (if Enrollee is a Minor)			
Full Legal Name (First, Middle Initial and Last):		Relationship to Enrollee: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -

INSURANCE REQUESTED	
[Benefit(s) Included:]	Coverage Amount
[Accidental Death Benefit]	[as per the Policy Schedule]
[Accidental Dismemberment Benefit]	[as per the Policy Schedule]
[Exposure and Disappearance Benefit]	[as per the Policy Schedule]
[Accident Weekly Indemnity Benefit]	[as per the Policy Schedule]
[Catastrophe Cash Benefit]	[as per the Policy Schedule]
[Accident Medical Expense Benefit]	[as per the Rider]
[Accident Excess Integrated Medical Expense Benefit]	[as per the Rider]
[Accident Excess Corridor Medical Expense Benefit]	[as per the Rider]
[Heart Failure Benefit]	[as per the Policy Schedule]
[Policyholder Sponsored Activity Benefit]	[as per the Policy Schedule]
[Parent Reimbursement Benefit]	[as per the Policy Schedule]

[Carjacking Benefit]	[as per the Policy Schedule]
[Coma Benefit]	[as per the Policy Schedule]
[Common Carrier Benefit]	[as per the Policy Schedule]
[Critical Illness Benefit]	[as per the Policy Schedule]
[Emergency Treatment Benefit]	[as per the Policy Schedule]
[Felonious Assault Benefit]	[as per the Policy Schedule]
[Funeral Expense Benefit]	[as per the Policy Schedule]
[Higher Education Benefit]	[as per the Policy Schedule]
[In-Hospital Indemnity Benefit]	[as per the Policy Schedule]
[No Claim Discount]	[as per the Rider]
[Personal Property Benefit]	[as per the Policy Schedule]
[Rehabilitation Benefit]	[as per the Policy Schedule]
[Seat Belt/[Air Bag] Benefit]	[as per the Policy Schedule]
[Terrorism Benefit]	[as per the Policy Schedule]
[Travel Assistance Program]	[as per the Policy Schedule]
[Waiver of Premium Due to Loss of Employment Benefit]	[as per the Rider]
[Wellness Benefit]	[as per the Policy Schedule]
[                                  ]	[as per the Policy Schedule]]
<b>[Additional Coverage Amounts Requested</b> (please check all that apply):	<b>Coverage Amount</b> (please indicate amount):
<input type="checkbox"/> [Accidental Death Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accidental Dismemberment Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Exposure and Disappearance Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Weekly Indemnity Benefit]	[\$        ] [in increments of \$100] not to exceed [\$400] per week]
<input type="checkbox"/> [Catastrophe Cash Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Medical Expense Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Excess Integrated Medical Expense Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Excess Corridor Medical Expense Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Heart Failure Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Policyholder Sponsored Activity Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Parent Reimbursement Benefit]	[\$        ] [in increments of \$50] not to exceed [\$100] per week]
<input type="checkbox"/> [Carjacking Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Coma Benefit]	[\$        ] [in increments of \$1,000] not to exceed [\$5,000]]

<input type="checkbox"/> [Common Carrier Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Critical Illness Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Emergency Treatment Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Felony Assault Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Funeral Expense Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Higher Education Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [In-Hospital Indemnity Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Personal Property Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Rehabilitation Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Seat Belt/Air Bag] Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Terrorism Benefit]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Travel Assistance Program]	[\$ ] [in increments of \$1,000] not to exceed \$5,000]]
<input type="checkbox"/> [Wellness Benefit]	[\$ ] [in increments of \$25] not to exceed \$1,000]]
<input type="checkbox"/> [ ]	[ ]]

#### **[CRITICAL ILLNESS BENEFIT QUESTIONNAIRE**

1. Has the Enrollee ever been diagnosed with or treated for any of the following ( <i>Oregon residents only</i> : during the past ten (10) years):	
a. heart attack, angina, high blood pressure, chest pains, disease or disorder of the heart or circulatory system, diabetes?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?	<input type="checkbox"/> YES <input type="checkbox"/> NO]
2. Has the Enrollee ever tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or treated for acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has the Enrollee ever been advised of the need for a transplant, been evaluated for a transplant and/or currently on a transplant waiting list?	<input type="checkbox"/> YES <input type="checkbox"/> NO]

#### **BENEFICIARY DESIGNATION**

##### **Primary Beneficiary:**

Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
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Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
<b>Contingent Beneficiary:</b>		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

<b>PREMIUM INFORMATION:</b>	
Enrollee:	[\$0.000] [per \$[1,000] of <b>Principal Sum</b> ] [per month]
[Annual Premium Option:	[\$40.00]]
Frequency of Payment: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	
Method of Payment: <input type="checkbox"/> Credit Card <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/> Agency Bill [The Enrollee, or if the Enrollee is a minor, the Enrollee's Parent or Legal Guardian, must complete a separate authorization form for a [Credit Card] [or] [Bank Draft] payment.]	

### INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Enrollee hereby enrolls for Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

### It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic):	Date:
Parent or Legal Guardian's Signature (may be electronic):	Date:

<b>[AGENT INFORMATION]</b>	
Name of Agent:	Agent's State License Number:
Agent's Signature:	[Producer Number:     ]]